BATTLE CREEK TRANSIT
REDUCED FARE PROGRAM
ELIGIBILITY CERTIFICATION FORM

Applicant Full Name: _____
Address: _____
Phone number: Area Code ( ) _____

I hereby authorized the release of this information to Battle Creek Transit or it's designee for the purpose of determining eligibility for Reduced Fare.

Applicants are advised that the information provided herein is not confidential and is open to Battle Creek Transit (BCT) staff and Department of Transportation authorized officials for compliance reviews.

Applicant Signature: _____Date:_____

HEALTH CARE PROVIDER You are being asked to determine if this applicant meets the Federal Transit Administration (FTA) definition of "Disabled Person" (see reverse) and should be eligible to use BCT's services at reduced fare rates based on the abilities listed below.

To aide your determination regular transit users should posses the following abilities:

-Walk to a bus stop
-Get on and off a vehicle with stairs
-Read and understand information signs
-Understand or follow directions
-Wait standing 10 minutes
-Grasp cash, coins, handles or cords
-Hear announcements
-Standing on a moving bus

Please answer the following questions:

1. Does the applicant have a transportation disability that would qualify them for reduced fare? (Please check one) _____YES_____NO

2. Is the transportation disability permanent? (Please check one)____YES_____NO

3. In **detail,** please describe the applicant's condition and **HOW** it limits the applicant's ability to effectively use BCT vehicles based upon the functions listed above and the FTA definition of Disabled Persons. _____
_____
_____
_____
_____

Health Care Provider information:

Name: **(PLEASE PRINT)** _____
Phone number: Area Code ( ) _____
Health Care Provider Signature: _____Date:_____